

§ 155.120

of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and

(4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(d) *Governance principles.* (1) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.

(2) The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure.

(e) *SHOP independent governance.* (1) A State may elect to create an independent governance and administrative structure for the SHOP, consistent with this section, if the State ensures that the SHOP coordinates and shares relevant information with the Exchange operating in the same service area.

(2) If a State chooses to operate its Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers in the Exchange.

(f) *HHS review.* HHS may periodically review the accountability structure and governance principles of a State Exchange.

§ 155.120 Non-interference with Federal law and non-discrimination standards.

(a) *Non-interference with Federal law.* An Exchange must not establish rules that conflict with or prevent the application of regulations promulgated by HHS under subtitle D of title I of the Affordable Care Act.

(b) *Non-interference with State law.* Nothing in parts 155, 156, or 157 of this subchapter shall be construed to preempt any State law that does not pre-

45 CFR Subtitle A (10–1–14 Edition)

vent the application of the provisions of title I of the Affordable Care Act.

(c) *Non-discrimination.* (1) In carrying out the requirements of this part, the State and the Exchange must:

(i) Comply with applicable non-discrimination statutes; and

(ii) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

(2) Notwithstanding the provisions of paragraph (c)(1)(ii) of this section, an organization that receives Federal funds to provide services to a defined population under the terms of Federal legal authorities that participates in the certified application counselor program under § 155.225 may limit its provision of certified application counselor services to the same defined population, but must comply with paragraph (c)(1)(ii) of this section with respect to the provision of certified application counselor services to that defined population. If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other Exchange-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with paragraph (c)(1)(ii) of this section.

[77 FR 11718, Feb. 27, 2012, as amended at 79 FR 30342, May 27, 2014]

§ 155.130 Stakeholder consultation.

The Exchange must regularly consult on an ongoing basis with the following stakeholders:

(a) Educated health care consumers who are enrollees in QHPs;

(b) Individuals and entities with experience in facilitating enrollment in health coverage;

(c) Advocates for enrolling hard to reach populations, which include individuals with mental health or substance abuse disorders;

(d) Small businesses and self-employed individuals;

Department of Health and Human Services

§ 155.170

(e) State Medicaid and CHIP agencies;

(f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, that are located within such Exchange's geographic area;

(g) Public health experts;

(h) Health care providers;

(i) Large employers;

(j) Health insurance issuers; and

(k) Agents and brokers.

§ 155.140 Establishment of a regional Exchange or subsidiary Exchange.

(a) *Regional Exchange.* A State may participate in a regional Exchange if:

(1) The Exchange spans two or more States, regardless of whether the States are contiguous; and

(2) The regional Exchange submits a single Exchange Blueprint and is approved to operate consistent with § 155.105(c).

(b) *Subsidiary Exchange.* A State may establish one or more subsidiary Exchanges within the State if:

(1) Each such Exchange serves a geographically distinct area; and

(2) The area served by each subsidiary Exchange is at least as large as a rating area described in section 2701(a) of the PHS Act.

(c) *Exchange standards.* Each regional or subsidiary Exchange must:

(1) Otherwise meet the requirements of an Exchange consistent with this part; and

(2) Meet the following standards for SHOP:

(i) Perform the functions of a SHOP for its service area in accordance with subpart H of this part; and

(ii) Encompass the same geographic area for its regional or subsidiary SHOP and its regional or subsidiary Exchange except:

(A) In the case of a regional Exchange established pursuant to § 155.100(a)(2), the regional SHOP must encompass a geographic area that matches the combined geographic areas of the individual market Exchanges established to serve the same set of States establishing the regional SHOP; and

(B) In the case of a subsidiary Exchange established pursuant to § 155.100(a)(2), the combined geographic

area of all subsidiary SHOPS established in the State must encompass the geographic area of the individual market Exchange established to serve the State.

[77 FR 11718, Feb. 27, 2012, as amended at 78 FR 54134, Aug. 30, 2013]

§ 155.150 Transition process for existing State health insurance exchanges.

(a) *Presumption.* Unless an exchange is determined to be non-compliant through the process in paragraph (b) of this section, HHS will otherwise presume that an existing State exchange meets the standards under this part if:

(1) The exchange was in operation prior to January 1, 2010; and

(2) The State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act, according to the Congressional Budget Office estimates for projected coverage in 2016 that were published on March 30, 2011.

(b) *Process for determining non-compliance.* Any State described in paragraph (a) of this section must work with HHS to identify areas of non-compliance with the standards under this part.

§ 155.160 Financial support for continued operations.

(a) *Definition.* For purposes of this section, participating issuers has the meaning provided in § 156.50.

(b) *Funding for ongoing operations.* A State must ensure that its Exchange has sufficient funding in order to support its ongoing operations beginning January 1, 2015, as follows:

(1) States may generate funding, such as through user fees on participating issuers, for Exchange operations; and

(2) No Federal grants under section 1311 of the Affordable Care Act will be awarded for State Exchange establishment after January 1, 2015.

§ 155.170 Additional required benefits.

(a) *Additional required benefits.* (1) A State may require a QHP to offer benefits in addition to the essential health benefits.

(2) A State-required benefit enacted on or before December 31, 2011 is not